Assembly Bill No. 2742

Passed the Assembly August 31, 2006

_____

Chief Clerk of the Assembly

Passed the Senate August 30, 2006

_____

Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2006, at _____ o'clock ___M.

_____

Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 14132 and 14503 of, and to add Sections 14105.07, 14459.6, and 14501.2 to, the Welfare and Institutions Code, relating to family planning.

LEGISLATIVE COUNSEL'S DIGEST

AB 2742, Nava. Family planning: Medi-Cal: Family PACT program.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services and under which qualified low-income persons receive health care benefits, including family planning benefits. Family planning benefits under the Medi-Cal program are administered by the Office of Family Planning within the department. Existing law imposes specified duties on the Office of Family Planning with respect to the administration of these benefits.

Existing law establishes a federally approved Medi-Cal waiver program, known as the Family Planning, Access, Care, and Treatment (Family PACT) program, administered by the Office of Family Planning, under which eligible individuals may receive specified family planning benefits.

This bill would make legislative findings and declarations regarding family planning services in California. The bill would require that family planning services applicable to the Medi-Cal program be identical to those required pursuant to the Family PACT program.

Existing law allows the department to contract with managed care plans for the provision of services under the Medi-Cal program.

This bill would require a Medi-Cal managed care plan to reimburse each nonprepaid health plan provider of family planning services at the applicable Medi-Cal rate appropriate to the provider type. It would require the plan to reimburse each correctly completed, valid claim from a nonprepaid health plan provider within 45 working days of receipt of the claim, to return an incomplete claim to an out-of-plan provider within 45 working days of receipt of the claim, and to ensure that 90% of

correctly completed claims for payment are paid within 30 calendar days of receipt, consistent with federal law.

This bill would prohibit a Medi-Cal managed care plan from restricting the choice of an enrollee regarding the provider from whom the enrollee may receive family planning services, so long as the provider is a Medi-Cal provider.

Existing law provides that, if federal financial participation is eliminated for any services identified as comprehensive clinical family planning services under the Family PACT program, all persons who have received or are eligible to receive those services shall receive the services pursuant to other provisions of law, as specified.

This bill would also provide that if federal financial participation is eliminated under the Family PACT program for mammography services or the hepatitis B vaccine, all persons who have received or are eligible to receive those services shall receive them pursuant to other provisions of law, as specified.

The bill would require the Office of Family Planning to consult with the Medi-Cal Managed Care Division of the department in the development of goals for the provision of family planning services by managed care plans, and to finalize those goals by August 1, 2007. It would require the department to evaluate the performance of the managed care plans in meeting those goals, and to provide an update on this evaluation to the appropriate policy and fiscal committees of the Legislature by September 1, 2008.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares the following:

(a) Family planning services are essential to the well-being of California women and their families.

(b) The poverty status of women is closely linked to unintended pregnancy.

(c) Family planning is a preventive health care service that can meet its goals of reducing unintended pregnancy only through a public health model that embraces maximum utilization.

(d) The 2005 Evaluation of the Family PACT program found the following:

(1) The Family PACT program averted more than 200,000 unintended pregnancies in 2002.

(2) Billions of dollars in cost savings to the state are attributable to the Family PACT program's impact on the number of unintended pregnancies in California.

(3) In addition to these savings, the Family PACT program saved $7.1 to $10 million in medical costs through its provision of chlamydia testing and treatment services.

(4) Annual cervical cancer screening in the Family PACT program averted almost 10,000 lifetime cases of cervical cancer, with most averted cases occurring among women younger than 30 years of age.

(5) The Family PACT program is credited with increasing by 16 percent the met need for family planning services of women. However, California is still faced with an unmet need of 43 percent.

(e) Recognition of the cost of unintended pregnancies, in human terms, societal costs, and government expenditures, has compelled the federal government to cover 90 cents ($0.90) for every dollar spent for Medi-Cal and Family PACT services to create incentives for state-administered family planning programs and to ensure the availability of services.

(f) Both the federal and state governments have recognized the importance of confidentiality and a high trust factor in the patient-provider relationship for these particularly sensitive services by requiring that individuals have freedom of choice in selecting their family planning providers.

(g) Maintaining two separate and distinct family planning programs with differing rules, billing codes, and benefits is costly and creates confusion for beneficiaries, providers, and administrators of the programs.

SEC. 2. Section 14105.07 is added to the Welfare and Institutions Code, to read:

14105.07. (a) A Medi-Cal managed care plan shall reimburse each nonprepaid health plan provider of family planning services at the applicable Medi-Cal rate appropriate to the provider type, as specified in Article 7 (commencing with Section 51501) of Chapter 3 of Division 3 of Title 22 of the California Code of Regulations. The plan shall reimburse each correctly completed, valid claim from a nonprepaid health plan provider within 45

working days of receipt of the claim. The plan shall return an incomplete claim to an out-of-plan provider within 45 working days of receipt of the claim. The plan shall ensure that 90 percent of correctly completed claims for payment are paid within 30 calendar days of receipt, consistent with federal law.

(b) Except as provided in subdivision (c), for purposes of this section, "nonprepaid health plan provider" means a Medi-Cal provider who has provided family planning services, including related clinical laboratory and pharmacy services, to a patient enrolled in a Medi-Cal managed care health plan, and who has not negotiated a contracted rate for the patient.

(c) Notwithstanding subdivision (b), "nonprepaid health plan provider" does not include a Medi-Cal provider who has negotiated a contracted rate for unassigned family planning patients and who has agreed to use the health plan's designated clinical laboratory and pharmacy for family planning-related services provided to these unassigned patients.

SEC. 3. Section 14132 of the Welfare and Institutions Code, as amended by Chapter 95 of the Statutes of 2006, is amended to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy and occupational therapy, are covered subject to utilization controls.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls.

Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for the developmentally disabled are covered subject to utilization controls.

(d) (1) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(2) Purchase of drugs used to treat erectile dysfunction or any off-label uses of those drugs are covered only to the extent that federal financial participation is available.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and X-ray services are covered, subject to utilization controls. Nothing in this subdivision shall be construed to require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable X-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated, is covered subject to utilization controls. When there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

Therapeutic shoes and inserts are covered when provided to beneficiaries with a diagnosis of diabetes, subject to utilization

controls, to the extent that federal financial participation is available.

(*l*) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Family planning services are covered, subject to utilization controls. Family planning services shall be identical to those required pursuant to the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program described in paragraph (8) of subdivision (aa).

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, other prophylaxis treatment for children 17 years of age and under, are covered.

(2) All dental hygiene services provided by a registered dental hygienist in alternative practice pursuant to Sections 1768 and 1770 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article.

(2) All providers enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, “in-home medical care service” includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

As used in this subdivision, in-home medical care services, include, but are not limited to:

(1) Level of care and cost of care evaluations.

(2) Expenses, directly attributable to home care activities, for materials.

(3) Physician fees for home visits.

(4) Expenses directly attributable to home care activities for shelter and modification to shelter.

(5) Expenses directly attributable to additional costs of special diets, including tube feeding.

(6) Medically related personal services.

(7) Home nursing education.

(8) Emergency maintenance repair.

(9) Home health agency personnel benefits which permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(11) Emergency and nonemergency medical transportation.

(12) Medical supplies.

(13) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(14) Utility use directly attributable to the requirements of home care activities which are in addition to normal utility use.

(15) Special drugs and medications.

(16) Home health agency supervision of visiting staff which is medically necessary, but not included in the home health agency rate.

(17) Therapy services.

(18) Household appliances and household utensil costs directly attributable to home care activities.

(19) Modification of medical equipment for home use.

(20) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(21) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

Beneficiaries receiving in-home medical care services are entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the

Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services may be covered to the extent that federal financial participation is available for those services under waivers granted in accordance with Section 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service which is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services which are authorized and reimbursable under this chapter, and services which are not reimbursable under this chapter, that portion of the claim for the treatment and

services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for beneficiaries with a diagnosis of AIDS or ARC, who require intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to individual beneficiaries in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible beneficiaries. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department, a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program.

(2) The department shall seek a waiver for a program to provide comprehensive clinical family planning services as described in paragraph (8). The program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. The services shall be provided under the program

only if the waiver is approved by the federal Centers for Medicare and Medicaid Services in accordance with Section 1396n of Title 42 of the United States Code and only to the extent that federal financial participation is available for the services.

(3) Solely for the purposes of the waiver and notwithstanding any other provision of law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other provision of law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, without taking regulatory action, the provisions of the waiver after its approval by the federal Health Care Financing Administration and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) In the event that the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) is no longer cost effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) (A) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(B) In the event the federal government eliminates federal financial participation under the waiver described in paragraph (2) for mammography or the hepatitis B vaccine, all persons who have received or are eligible to receive services pursuant to that waiver shall receive mammography services or the hepatitis B vaccine under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive mammography services or the hepatitis B vaccine under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, "comprehensive clinical family planning services" means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family

planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning-related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at the next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical

history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(ab) Purchase of prescribed enteral formulae is covered, subject to the Medi-Cal list of enteral formulae and utilization controls.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

SEC. 4. Section 14459.6 is added to the Welfare and Institutions Code, to read:

14459.6. (a) The Office of Family Planning shall consult with the Medi-Cal Managed Care Division of the department in the development of goals for the provision of family planning services by managed care plans. These goals shall be finalized by the department by August 1, 2007.

(b) The department shall provide the goals developed pursuant to subdivision (a) to the managed care plans by September 1, 2007. By May 1, 2008, the department, as part of the routine medical survey, shall evaluate the performance of the managed care plans in meeting the goals established pursuant to subdivision (a). By September 1, 2008, the department shall provide an update to the appropriate policy and fiscal committees of the Legislature on the evaluation of the performance of the managed care plans in meeting the goals for the provision of family planning services established pursuant to subdivision (a).

SEC. 5. Section 14501.2 is added to the Welfare and Institutions Code, to read:

14501.2. (a) It is the intent of the Legislature to maximize utilization of family planning services for qualified beneficiaries under the Medi-Cal and Family PACT programs, and to lower administrative costs, by eliminating duplication in the development of family planning policy, use of billing codes, and determination of family planning benefits.

(b) Subject to the availability of federal financial participation, all family planning benefits, including services, drugs, and supplies, available to beneficiaries under the Medi-Cal and Family PACT programs shall be uniform and shall conform to the provisions of paragraph (8) of subdivision (aa) of Section 14132.

(c) Billing and reimbursement requirements for services provided to fee-for-service family planning patients shall be uniform. Fee-for-service billing codes for all Medi-Cal family planning services shall be identical to Family PACT program billing codes.

(d) In order to ensure strict confidentiality for patients desiring family planning services, patients shall have the right to choose their providers of care. A Medi-Cal managed care plan shall not restrict the choice of the enrollee regarding the provider from whom the enrollee may receive family planning services, so long as the provider is a Medi-Cal provider.

(e) Medi-Cal and Family PACT family planning providers that dispense drugs and supplies, including community clinics licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code, shall be permitted to dispense all covered comprehensive family planning drugs and supplies that they are licensed to dispense.

SEC. 6. Section 14503 of the Welfare and Institutions Code is amended to read:

14503. (a) Family planning services shall be offered to all former, current, or potential recipients of childbearing age (as provided by Public Law 92-603) and provided to all eligible individuals who voluntarily request the services. The services shall be offered and provided without regard to marital status, age, or parenthood. Notwithstanding any other provisions of law, the furnishing of these family planning services shall not require the consent of anyone other than the person who is to receive them. Within the meaning of this section, the term “former, current, or potential recipient” means all persons eligible for Medi-Cal benefits under Chapter 7 (commencing with Section 14000) and all persons eligible for public social services for which federal reimbursement is available under the federal Social Security Act (42 U.S.C. Sec. 301 et seq.), except that the term “potential recipients” includes all persons in a family where current social, economic, and health conditions of the family indicate that the family would likely become a recipient of financial assistance within the next five years.

(b) Family planning services shall be identical to those required pursuant to the Family Planning, Access, Care, and

Treatment (Family PACT) Waiver Program described in paragraph (8) of subdivision (aa) of Section 14132.

(c) To the extent that facilitating services, such as transportation and child care services, needed to attend clinic or other appointments are not available under the Medi-Cal program, they shall be provided by a grantee pursuant to a grant awarded by the Office of Family Planning to the extent that an appropriation for this purpose is made through the annual budget process. These grants shall include to the maximum extent possible, cooperative funding and other financial arrangements that permit maximum use of available federal funds. All grants awarded by the Office of Family Planning shall be exempt from Division 2 (commencing with Section 1100) of the Public Contract Code. Information and referral services only shall be available to all other families and children.

(d) As the single state agency responsible for the state plan under Title XX of the federal Social Security Act (42 U.S.C. Sec. 1397 et seq.), the State Department of Social Services may provide family planning services pursuant to a purchase of services agreement with the department from funds appropriated for those services. The agreement shall authorize the Office of Family Planning to implement a sliding fee schedule for family planning services provided to clients pursuant to Title XX of the federal Social Security Act in accordance with Section 14501.5.

Approved _____, 2006

_____

Governor